

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? () Yes (X) No
Requestor Vista Medical Center Hospital 4301 Vista Rd. Pasadena, TX 77504	MDR Tracking No.: M4-03-8012-01
	TWCC No.:
	Injured Employee's Name:
Respondent TPCIGA for Reliance National Insurance Rep. Box #50	Date of Injury:
	Employer's Name: Aramark Corp.
	Insurance Carrier's No.: 900962173

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
7-1-02	7-12-02	Inpatient Hospitalization	\$60,727.49	\$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Carrier did not forward an explanation of missing documentation within 14 days of receipt of the medical bill in compliance with Texas Administrative Code. All TWCC-required documentation has been forwarded to the Carrier.

PART IV: RESPONDENT'S POSITION SUMMARY

Position statement was not submitted.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed \$40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by both parties, it **does** appear that this particular admission involved "unusually extensive services." In particular, this admission resulted in a hospital stay of 11 days based upon posterior cervical decompression including laminectomy and foraminotomy C3-4 to C6-7; and Posterior cervical arthrodesis C3-7. Accordingly, the stop-loss method does apply and the reimbursement is to be based on the stop-loss methodology.

The hospital billed \$139,841.27 for the hospitalization.

The insurance carrier paid \$44,153.46 based upon half payment was made pending receipt of medical records. Documentation does not support charges.

The implantables were billed at \$22,098.70, and payment was denied based upon disallowed pending receipt of invoice. The requestor did not submit cost invoices to support charges.

The requestor did not submit persuasive documentation to challenge the insurance carrier's audit; therefore, additional reimbursement is not recommended.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Authorized Signature

Elizabeth Pickle

Typed Name

April 27, 2005

Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____